PATIENT HEALTH HISTORY

Please complete this questionnaire by answering each section as completely as possible, to the best of your knowledge, as to how you have felt since your problem(s) began. It is designed to provide information for the doctor in order to better assess your condition, and to be able to treat you in the most beneficial manner.

In the diagram below, please mark where your pain is located by placing the letter associated with the description of the pain in that area. If more than one complaint or type of pain is present, please note that as well in the area of complaint/pain.

A = ACHE

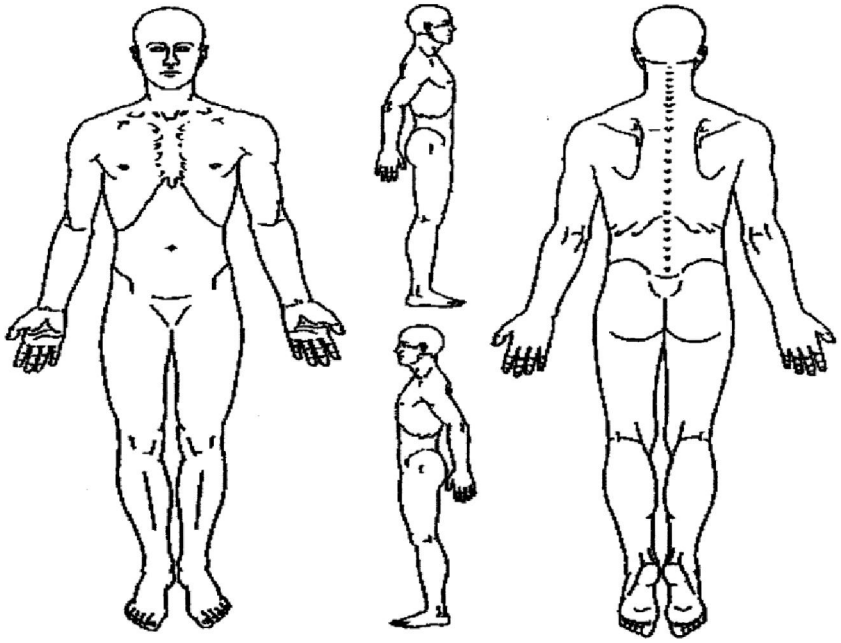
B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

O = OTHER_____



Briefly describe your PRIMARY COMPLAINT:

_____

When and how did your symptoms begin?

_____

How has the severity of your condition changing, since its onset? (circle)
Much worse *Worse* *A little worse* *No change* *A little better* *Better* *Much better*

Your average pain level is (circle): No pain 1 2 3 4 5 6 7 8 9 10 Worst

How often do you experience your symptoms? (circle)
Constantly (100-76% of the time) *Frequently (75-51% of the time)* *Occasionally (50-26% of the time)* *Intermittently (25-0% of the time)*

Is there a time of day your symptoms seem to be worse? _____

Does this pain shoot, radiate, or travel in your body? If so, Where?_____

Are you experiencing any stiffness or weakness? If so, Where?_____

What activities make your condition/pain worse?_____

What activities make your condition/pain better?_____

How much have your symptoms interfered with your usual daily activities? *Not at all* *A little bit* *Moderately* *Quite a bit* *Extremely*

If so, what daily activities have been affected? _____

Is there anything else that should be known about your complaint? _____

Have you seen another doctor for this complaint? If yes, provide dr's name, type of doctor, date seen, and diagnosis in the space below.

Briefly describe your SECONDARY COMPLAINT, (if any):

_____

When and how did your symptoms begin?

_____

How has the severity of your condition changing, since its onset? (circle)
Much worse *Worse* *A little worse* *No change* *A little better* *Better* *Much better*

Your average pain level is (circle): No pain 1 2 3 4 5 6 7 8 9 10 Worst

How often do you experience your symptoms? (circle)
Constantly (100-76% of the time) *Frequently (75-51% of the time)* *Occasionally (50-26% of the time)* *Intermittently (25-0% of the time)*

Is there a time of day your symptoms seem to be worse? _____

Does this pain shoot, radiate, or travel in your body? If so, Where?_____

Are you experiencing any stiffness or weakness? If so, Where?_____

What activities make your condition/pain worse?_____

What activities make your condition/pain better?_____

How much have your symptoms interfered with your usual daily activities? *Not at all* *A little bit* *Moderately* *Quite a bit* *Extremely*

If so, what daily activities have been affected? _____

Is there anything else that should be known about your complaint? _____

Have you seen another doctor for this complaint? If yes, provide dr's name, type of doctor, date seen, and diagnosis in the space below.

Do you have any other complaints that need to be addressed? _____

SOCIAL HISTORY					
HABITS	***NONE***	***LIGHT***	***MODERATE***	***HEAVY***	***DETAILS / DESCRIPTION/ AMOUNT***
EXERCISE					
SLEEP					
STRESS					
WATER					
ALCOHOL					
TOBACCO					
DRUGS					
CAFFEINE					
SOFT DRINKS					
SUGAR/SALT					
ARTIFICIAL SWEETENER					

PRESCRIPTION AND OVER THE COUNTER MEDICATIONS	NUTRITIONAL SUPPLEMENTS
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

HOSPITALIZATIONS/SURGERIES	OUTPATIENT MEDICAL PROCEDURES	MEDICAL ALERTS (e.g., stint, port, screws, past heart attack or stroke)
CURRENT ILLNESSES (e.g., cancer, diabetes, depression)	**ALLERGIES**	**PREVIOUS DIAGNOSTIC TESTS (Within the last 6 Months)**
		X-ray: MRI: CT Scan: Other:

FAMILY HISTORY: *Please list any health conditions/illnesses any of these family members may have or had in the past. (e.g., cancer, heart attack/disease, stroke, diabetes, arthritis, genetic disorders)*	
Mother	
Father	
Sibling(s)	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	

REVIEW OF SYSTEMS ***Please put a "C" beside current issues, a "P" beside past issues, and leave non issues blank***

General	Throat	Musculoskeletal	Respiratory/Lungs	Gastrointestinal	Genitourinary
Weight loss	Sore throat	Weakness	Breathing difficulty	Nausea	Bladder control
Weight gain	Swallowing	Loss of motion	Shortness of breath	Vomiting	Voiding difficult
Fatigue	Tooth pain	Cramps	Chronic cough	Diarrhea	Burning
Fever/Chills	Bleeding Gums	Swelling	Asthma	Constipation	Painful urination
Cancer	**Endocrine**	Arthritis	Bronchitis	Dark stools	Kidney stones
Eyes	Thyroid	Joint pain	Emphysema	Bloody stools	Hernia
Far sighted	Diabetes	Muscle aches	Pneumonia	Hemorrhoids	Urgency
Near sighted	X Thirsty	**Cardiovascular**	Snoring	Appetite change	Frequency
Blurry vision	X Hungry	High Blood Pressure	Wheezing	Bloating	Dark urine
Double vision	X Urination	Low Blood Pressure	Blood in sputum	Excessive gas	Foul urine
Vision loss	Night Sweats	Chest pain at rest	**Neurological**	Abdominal pain	Blood in urine
Glaucoma	Temp Intolerant	Chest pain w/ activity	Headaches	Ulcers	Pelvic pain
Ears	**Immunologic**	Palpitations	Numbness	Heartburn	Nocturia
Hearing loss	Hives/Rash	Leg cramps	Tingling	Indigestion	Genital sores
Ringing	Infections	Lightheadedness	Tremors	Yellow skin color	UT Infection
Dizziness	Lymph nodes	Stroke	Loss of balance	**Psychological**	**Women Only**
Infection	Bruising	Blue nails/lips	Excessive sleep	Depression	Heavy menses
Nose	**Skin**	Cold extremities	Memory loss	Easily Angered	Irregular period
Sinuses	Itching	Varicose veins	Seizures	Anxiety	Painful cramps
Nosebleeds	Hair loss	Blood clots	Speech difficulties	Eating Disorder	PMS
Loss of smell	Nail changes	Heart murmur	Incoordination	Mental Issues	Breast Lumps

Please list any other issues you have now Or have had in the past that are not listed	

Patient Name: **(Print)**_____ **(Sign)**_____ **Date:**_____

Parent/Legal Guardian (If under 18): **(Print)**_____ **(Sign)**_____

Relationship to Minor:_____